

ATTACHMENT 3

Sample CMS 1500 claim form for hearing instrument specialist services

HEALTH INSURANCE CLAIM FORM																																																																																																																																																																				
<div style="display: flex; justify-content: space-between;"> <div> <div style="display: flex; align-items: center;"> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA </div> <div style="display: flex; justify-content: space-between;"> <div> 1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input checked="" type="checkbox"/> (Medicaid #) CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (VA File #) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID) </div> <div> 1a. INSURED'S I.D. NUMBER 1234567890 </div> </div> </div> </div>																																																																																																																																																																				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A.					3. PATIENT'S BIRTH DATE MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F																																																																																																																																																															
5. PATIENT'S ADDRESS (No., Street) 609 Willow					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																																																																																																																																															
CITY Anytown STATE WI					CITY _____ STATE _____																																																																																																																																																															
ZIP CODE 55555 TELEPHONE (Include Area Code) (XXX) XXX-XXXX					ZIP CODE _____ TELEPHONE (INCLUDE AREA CODE) _____																																																																																																																																																															
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) O-I-P					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE																																																																																																																																																															
a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME					11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																																																																																																																																															
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____																																																																																																																																																																				
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																																																																																																																																				
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY																																																																																																																																																															
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE I.M. Prescribing					17a. I.D. NUMBER OF REFERRING PHYSICIAN X12345																																																																																																																																																															
19. RESERVED FOR LOCAL USE					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____ 22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____ 23. PRIOR AUTHORIZATION NUMBER 1234567																																																																																																																																																															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)																																																																																																																																																																				
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3">A DATE(S) OF SERVICE From To</th> <th colspan="2">B Place of Service</th> <th colspan="2">C Type of Service</th> <th colspan="2">D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER</th> <th colspan="2">E DIAGNOSIS CODE</th> <th colspan="2">F \$ CHARGES</th> <th colspan="2">G DAYS OR UNITS</th> <th colspan="2">H EPST Family Plan</th> <th colspan="2">I EMG</th> <th colspan="2">J COB</th> <th colspan="2">K RESERVED FOR LOCAL USE</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>10</td> <td>31</td> <td>03</td> <td></td> <td>11</td> <td></td> <td>V5030</td> <td></td> <td>1</td> <td></td> <td>\$XXX XX</td> <td>1.0</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2</td> <td>10</td> <td>31</td> <td>03</td> <td></td> <td>11</td> <td></td> <td>V5241</td> <td></td> <td>1</td> <td></td> <td>\$XXX XX</td> <td>1.0</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>4</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>6</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>										A DATE(S) OF SERVICE From To			B Place of Service		C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS CODE		F \$ CHARGES		G DAYS OR UNITS		H EPST Family Plan		I EMG		J COB		K RESERVED FOR LOCAL USE		1	10	31	03		11		V5030		1		\$XXX XX	1.0										2	10	31	03		11		V5241		1		\$XXX XX	1.0										3																						4																						5																						6																					
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25. FEDERAL TAX I.D. NUMBER _____ SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO. _____					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																										
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Authorized MM/DD/YY SIGNED _____ DATE _____					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) I.M. Billing 1 W. Williams Anytown, WI 55555 PIN# _____ GRP# 87654321																																																																																																																																																															

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)